DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 2/22/14

PRINTED: 01/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445275	A. BUILDING 01 - MAIN BUILDING 01 B. WING	01/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF JEFFERSON CITY	336 WEST OLD ANDREW JOHNSON HWY JEFFERSON CITY, TN 37760

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the fire rated construction. The findings include: Observation on January 7, 2014, at 1:30 p.m. revealed the unit 2 nurses station has 2 penetrations in the 1 hour fire rated ceiling assembly. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on January 7, 2014.	K 029	**K029 NFPA 101 LIFE SAFETY CODE STANDARD** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Maintenance Department will repair the 2 penetrations in the 1 hour fire rated ceiling above the Unit 2 nurses station with approved materials on or before 2/7/14. **How will you identify other residents having the potential to be affected by the same deficient practice?** Maintenance Department will examine the facility to ensure there are no additional penetrations in the fire rated construction of the building. Any areas found will be repaired with approved materials. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Maintenance Director/designee will conduct a monthly audit for 3 months to ensure our facility maintains its fire rated construction. **How will the corrective action be monitored to ensure the deficient**	2/22/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jonathan B Henderson — TITLE: Executive Director — (X6) DATE: 1/31/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062	**K062 NFPA LIFE SAFETY CODE STANDARD** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	2/22/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jennifer R Henderson | TITLE: Executive Director | (X6) DATE: 1/31/14

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K 062	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and testing, the facility failed to provide the sprinkler riser with adequate heat. The findings include: Observation and testing on January 7, 2014, at 1:50 p.m. and 5:10 p.m. revealed the following: 1. Sprinkler riser room does not have any permanent heat source installed. The room has two (2) louvered openings in the exterior wall by the sprinkler riser making it susceptible to freezing. 2. The heater in the attic space for the sprinkler system above room 204 was not working when tested. These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on January 7, 2014.	K 062	Maintenance Department repaired the heater in the attic space for the sprinkler system above room #204 on 1/7/14. A thermometer was installed in the sprinkler riser room on 1/29/14, so temperature can be monitored. If temperature drops below 40 degrees Fahrenheit, radiant heat will be provided to this room to maintain the appropriate temperature. This was Stuart Hurwitz's recommendation. **How will you identify other residents having the potential to be affected by the same deficient practice?** Maintenance Department examined all heaters in the attic space to ensure they are working properly. Maintenance Department also placed thermometers in each attic fire compartment throughout the facility to ensure appropriate temperatures are maintained for areas susceptible to sprinkler system freezing. If temperature in any of these areas drops below 40 degrees, additional heat and/or insulation will be provided. This was all completed on or before 1/31/14. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Maintenance associates were inserviced by ED by 1/31/14 to check and log temperatures for all sprinkler areas daily	2/22/14

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K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.	K 066	**K066 NFPA LIFE SAFETY CODE STANDARD** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** On 1/28/14 two self-closing steel cans were ordered (one for each of the two smoking areas). Two metal buckets were also ordered to go down inside the cans in order to provide the required self-closing cover device into which ashtrays can be emptied. This was Stuart Hurwitz's recommendation.	2/22/14

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K 066	Continued From page 2 (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation, the facility failed to provide metal containers with self-closing cover devices into which ashtrays can be emptied into. The findings include: Observation on January 7, 2014 at 5:30 p.m. revealed 2 of 2 smoking areas were not provided with metal containers with self-closing cover devices into which ashtrays can be emptied into, that are readily available. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on January 7, 2014.	K 066	**How will you identify other residents having the potential to be affected by the same deficient practice?** No other residents have the potential to be affected because we are switching to an approved container in both of our two smoking areas. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Maintenance director/designee will audit weekly to ensure that the two new self-closing cover devices into which ashtrays can be emptied are in place and functioning properly. This audit will be performed for 3 months or until 100% compliance is achieved. **How will the corrective action be monitored to ensure the deficient practice will not re-occur, i.e., what quality assurance program will be put into place?** The Performance Improvement committee includes the Executive Director, Director of Nursing, Medical Director, Consultant Pharmacist, Director of Rehabilitation Services, Director of Health Information, Director of Social Services, Director of Food Services, Director of Maintenance, Staff Development Coordinator, Skilled MDS Coordinator, Director of	2/22/14

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